DEPARTMENT OF CORPORATIONS
3700 Wilshire Boulevard, Suite 600
Los Angeles, CA 90010-3001

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: PLEASE FILL IN YOUR NAME AND HEALTH PLAN IN THE SPACE BELOW, SIGN AND DATE THIS AUTHORIZATION, AND RETURN IT TO THE LOS ANGELES OFFICE OF THE DEPARTMENT OF CORPORATIONS, ATTN: CONSUMER SERVICES UNIT.

IN THE EVENT THE ENROLLEE CANNOT SIGN THIS AUTHORIZATION ON HIS/HER OWN BEHALF (FOR EXAMPLE, IF ENROLLEE IS A MINOR), A PARENT OR GUARDIAN SHOULD COMPLETE FORM FOR ENROLLEE. PLEASE CALL OUR CONSUMER SERVICES UNIT AT (800) 400-0815 IF YOU HAVE ANY QUESTIONS.

_____ (person authorizing release) on behalf of

_____ (enrollee's name) hereby authorizes

_____ ("Plan")

to release to the Department of Corporations ("Department") his/her medical record(s) in the custody and/or control of the Plan including but not limited to all medical records in the possession of health care providers and any other information in the custody and/or control of the Plan concerning care provided to him/her relating to the Request for Assistance filed with the Department.

This authorization for release of information may be revoked or withdrawn at any time and a revocation or withdrawal will apply to all information not previously released pursuant to this authorization.

This authorization for release of information will expire one year following the date indicated below and the expiration will apply to all information not previously released pursuant to this authorization.

YOUR MEDICAL RECORDS WILL ONLY BE OBTAINED IF IT IS DETERMINED TO BE NECESSARY IN ORDER TO COMPLETE A REVIEW OF YOUR REQUEST FOR ASSISTANCE. THE MEDICAL RECORDS REQUESTED SHALL INCLUDE ONLY THOSE MEDICAL RECORDS RELEVANT TO A REVIEW OF YOUR MATTER. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

THIS MEDICAL AUTHORIZATION FORM IS NOT MANDATORY. HOWEVER, FAILURE TO PROVIDE THIS FORM MAY PRECLUDE FURTHER CONSIDERATION OF YOUR REQUEST FOR ASSISTANCE.

Signed _____ Date _____